907 KAR 1:560. Medicaid hearings and appeals regarding eligibility.

RELATES TO: KRS Chapter 13B, 205.231, 205.237, 205.520, 42 C.F.R. 431 subpart E, 42 U.S.C. 1396

STATUTORY AUTHORITY: KRS 194A.025(1), 194A.030(2), 194A.050(1), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes provisions relating to the Medicaid grievance, hearing and appeal process regarding Medicaid eligibility issues.

Section 1. Definitions. (1) "Applicant" means an individual applying for Medicaid.

(2) "Authorized representative" means an individual acting on behalf of an applicant or recipient.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Designated hearing agency" means the Department for Social Insurance.

(5) "Recipient" means an individual who receives Medicaid.

Section 2. Informing the Applicant or Recipient of His Rights. With the exception of a dispute resolution regarding a utilization review denial, which shall be processed in accordance with 906 KAR 1:080, the following provisions shall apply:

(1) An applicant or recipient shall be informed of his right to a hearing:

(a) Verbally and in writing when application is made; and

(b) In writing if an action is taken affecting his eligibility in accordance with KRS 13B.050.

(2) An applicant or recipient shall be informed of the method by which he may obtain a hearing and that he may be represented by:

(a) Legal counsel;

(b) A relative;

(c) A friend;

(d) Other spokesperson; or

(e) Himself.

Section 3. Request for a Hearing. With the exception of a dispute resolution regarding a utilization review denial, which shall be processed in accordance with 906 KAR 1:080, the following provisions shall apply:

(1) An applicant, recipient or an authorized representative may request a hearing by filing a request with the designated hearing agency at the local office or central office.

(2) The applicant, recipient or authorized representative shall clearly indicate a desire for a hearing by submitting a statement:

(a) In written form; or

(b) Verbally and followed up in writing.

(3) An applicant, recipient or authorized representative may use Form PAFS-78, Request for Hearing, Appeal, or Withdrawal, to submit the written request.

Section 4. Time Limitation for Request. (1) To be considered timely, a written or verbal (with appropriate follow-up in writing) request from an applicant, recipient or authorized representative with regard to an action or a delay in taking a timely action by the Department for Medicaid Services or its

designee regarding Medicaid eligibility shall be received by the designated hearing agency within:

(a) Thirty (30) days of the notice of:

1. Denial of an application;

2. Discontinuance of an active case;

3. Increase in patient liability; or

(b) A time period equal to the delay in action by the agency.

(2) An additional thirty (30) days for requesting a hearing shall be granted if it is determined by the hearing officer that the delay was for good cause in accordance with the following criteria:

(a) The applicant or recipient was away from home during the entire filing period;

(b) The applicant or recipient is unable to read or to comprehend the right to request a hearing on the notice of:

1. Adverse action;

2. Discontinuance of Medicaid eligibility; or

3. Increase in patient liability;

(c) The applicant or recipient moved resulting in delay in receiving or failure to receive the notice of:

1. Adverse action;

2. Discontinuance of the Medicaid eligibility;

3. Increase in patient liability;

(d) Serious illness of the applicant or recipient; or

(e) The delay was no fault of the applicant or recipient.

Section 5. Continuation of Medicaid. (1) Except as provided in subsection (3) or (4) of this section, Medicaid eligibility shall be continued at the level prior to the adverse action through the month in which the hearing officer's decision is:

(a) Rendered if the request results from dissatisfaction regarding a:

1. Proposed discontinuance; or

2. Proposed increase in patient liability; and

(b) Received within ten (10) days of the date of the:

1. Advance notice of adverse action; or

2. Notice of discontinuance from the Department for Medicaid Services or its designee.

(2) Except as provided in subsection (4) of this section, Medicaid shall be reinstated and continued through the month in which the hearing officer's decision is rendered if:

(a) The request is received within twenty (20) days of the date of the advance notice of:

1. Adverse action;

2. Discontinuance of Medicaid eligibility; or

3. Increase in patient liability; and

(b) The reason for delay meets the good cause criteria established in Section 4(2) of this administrative regulation.

(3) Subsection (1) of this section shall not apply if the applicant, recipient or authorized representative requests the discontinuance or increase in patient liability to be in effect pending the hearing decision.

(4) Subsections (1) and (2) of this section shall not apply if the program benefit has been reduced or discontinued as a result of a change in law or administrative regulation.

(5) A continued or reinstated benefit shall be considered an overpayment if the agency decision is upheld.

(6) A time limited benefit shall not be extended based on a request for an appeal or hearing.

Section 6. Acknowledgement of the Request. (1) A hearing request shall be acknowledged by the

designated hearing agency.

(a) The acknowledgement letter shall contain information regarding:

1. The hearing process;

2. The right to case record review prior to the hearing;

3. The right to representation; and

4. A statement that the local office can provide information regarding the availability of free representation by legal aid or a welfare rights organization within the community.

(b) Subsequent notification shall comply with the requirements of KRS 13B.050.

(2) A party to the hearing shall be provided at least twenty (20) days timely notice of the hearing to permit adequate preparation of the case. Less timely notice may be requested by the applicant, recipient or authorized representative to expedite the scheduling of the hearing.

(3) A hearing complying with the requirements of KRS Chapter 13B shall be scheduled on a timely basis to assure no more than ninety (90) days shall elapse from the date of the request to the date of the decision, with the exception that a hearing determination regarding a community spouse income or resource allowance shall be held within thirty (30) days of the hearing request date.

Section 7. Withdrawal or Abandonment of Request. (1) The applicant, recipient or authorized representative:

(a) May withdraw his request for a hearing prior to release of the hearing officer's decision; and

(b) Shall be granted the opportunity to discuss withdrawal with his legal counsel or representative prior to finalizing the action.

(2) Abandonment of request.

(a) A hearing request shall be considered abandoned if the applicant, recipient or authorized representative fails without prior notification to report for the hearing.

(b) A hearing request shall not be considered as abandoned without extending to the applicant or recipient, and, if applicable, his legal counsel or representative, a period of ten (10) days to establish that the failure was for good cause in accordance with the good cause criteria established in Section 4(2) of this administrative regulation.

Section 8. Applicant's or Recipient's Rights Prior to a Hearing. (1) An applicant or recipient shall receive notice consistent with KRS 13B.050 including the right to:

(a) Legal counsel or other representation;

(b) Review the case record relating to the issue; and

(c) Submit additional information in support of his claim.

(2) If the hearing involves medical issues:

(a) A medical assessment by other than a person involved in the original decision shall be obtained at the department's expense if the hearing officer considers it necessary; and

(b) If a medical assessment at the department’s expense is requested by the applicant, recipient or authorized representative and denied by the hearing officer, the reason for denial shall be set forth in writing.

Section 9. Postponement of a Hearing. (1) The applicant, recipient or authorized representative may request and shall be entitled to a postponement of a hearing if the request is made:

(a) Before the hearing; and

(b) In accordance with the good cause criteria established in Section 4(2) of this administrative regulation.

(2) The decision to grant the postponement shall be made by the hearing officer.

(a) The postponement of the hearing shall not exceed thirty (30) days from the date of the request.

(b) The time limit for action on the decision shall be extended for as many days as the hearing is postponed.

Section 10. Corrective Action for Medicaid. (1) The department may determine that corrective action to provide or restore eligibility is appropriate if:

(a) A hearing has been requested;

(b) A hearing decision has not been rendered; and

(c) The department's action or proposed action made the applicant or recipient ineligible for benefits to which he was entitled.

(2) After corrective action has been taken:

(a) The applicant, recipient or authorized representative shall be given the opportunity to withdraw the hearing request; and

(b) The hearing process shall continue if the applicant, recipient or authorized representative wishes to pursue the request.

Section 11. Conduct of a Hearing. (1) The hearing shall be conducted in accordance with the requirements of KRS 13B.080 and 13B.090.

(2) Impartiality. The hearing officer shall be impartial and shall disqualify himself as required by KRS 13B.040.

(3) The hearing shall be conducted in-state where the applicant, recipient or authorized representative may attend without undue inconvenience.

(4) If necessary to receive full information on the issue, the hearing officer may examine each party who appears and his witnesses.

(5) The hearing officer may schedule a hearing and take additional evidence as is deemed necessary. Evidence shall be taken in accordance with the provisions of KRS 13B.080 and 13B.090.

Section 12. The Decision. With the exception of a dispute resolution regarding a utilization review denial, which shall be processed in accordance with 906 KAR 1:080, the following provisions shall apply:

(1) After the hearing is concluded, the hearing officer shall issue a decision in accordance with the requirements of KRS 13B.110.

(2) A decision with regard to a community spouse's income allowance shall be subject to a downward adjustment as deemed necessary by the agency as circumstances causing financial duress change or no longer exist.

(a) The resource allowance shall be subject to this adjustment with regard to a resource that is:

1. Attributed to the community spouse; and

2. Not transferred within six (6) months of the Medicaid approval date.

(b) This adjustment shall be appealable pursuant to Section 5 of this administrative regulation.

(3) A copy of the decision shall be mailed to the applicant or recipient and his representative.

(4) The decision, with respect to the issue considered, shall be final unless further appeal is initiated within twenty (20) days from the date of mailing of the decision.

Section 13. Appeal from Decision of Hearing Officer for an Applicant and Recipient. (1) An applicant, recipient or his authorized representative wishing to appeal the decision of a hearing officer shall file an appeal to an appointed appeal board.

(2) The appeal request shall be considered timely if it is received in a local office or the central office of the designated hearing agency within twenty (20) days of the date on which the hearing officer's decision was mailed.

(3) If the good cause criteria established in Section 4(2) of this administrative regulation is met, an

appeal request received within thirty (30) days of the hearing officer's decision shall be considered timely.

(4) The request shall be:

(a) Filed:

1. In writing; or

2. Verbally, if a written request is subsequently sent; and

(b) Considered filed on the day the request is received.

(5) An applicant, recipient or authorized representative may use Form PAFS-78, Request for Hearing, Appeal or Withdrawal, to submit the written request.

(6) Medicaid eligibility shall continue to be denied, discontinued, patient liability increased, or Medicaid coverage reduced if the department's action is upheld by the hearing officer.

Section 14. Applicant's or Recipient's Rights Prior to an Appeal Board Consideration. (1) An appeal shall be acknowledged in writing to the applicant or recipient and his authorized representative.

(2) The acknowledgment shall offer the opportunity to file a brief or submit new and additional proof and state the tentative date on which the board shall consider the appeal.

Section 15. Appeal Board Review. (1) An appeal to the appeal board shall be considered upon the records of the department and the evidence or exhibits introduced before the hearing officer unless the applicant, recipient or authorized representative specifically requests permission to file additional proof.

(2) If an appeal is being considered on the record, a party may present a written argument and at the appeal board's discretion, be allowed to present an oral argument.

(3) If needed, the appeal board may direct the taking of additional evidence to resolve the appeal.

(4) Evidence shall be taken by the appeal board after seven (7) days notice to the parties, giving them the opportunity to object to the introduction of additional evidence or to rebut or refute the additional evidence.

Section 16. The Appeal Board Decision. The decision of the appeal board shall:

(1) Be duly signed by members of the appeal board;

(2) Set forth in writing the facts on which the decision is based; and

(3) Be irrevocable in respect to the issue in the individual case unless the decision is set aside through the judicial review process pursuant to KRS 13B.140 and 13B.150.

Section 17. Medicaid Case Actions Following a Decision. (1) A Medicaid case action following a decision of a hearing officer or the appeal board shall be made promptly and shall include:

(a) The month of application; or

(b) If it is established that the applicant or recipient was eligible during an entire period, the month in which the incorrect action of the department adversely affected the applicant or recipient.

(2) For a reversal involving an increase in patient liability, action shall be taken to reduce the patient liability within ten (10) days of the receipt of the hearing or appeal board decision.

Section 18. Medicaid Managed Care Provision of Services. (1) A dispute resolution between a recipient and a partnership or managed behavioral health care organization shall be in accordance with KRS 211.461 through 211.466 and 906 KAR 1:080.

(2) All other hearings or appeals relating to the Medicaid managed care provision of services shall be processed in accordance with 907 KAR 1:563.

Section 19. Limitation of Fees. (1) Pursuant to KRS 205.237, the maximum fee that an attorney

may charge the applicant or recipient for the representation in all categories of Medicaid shall be:

(a) Seventy-five (75) dollars for preparation and appearance at a hearing before a hearing officer;

(b) Seventy-five (75) dollars for preparation and presentation (brief included) of an appeal to the appeal board;

(c) $175 for preparation and presentation, including a pleading and appearance in court, of an appeal to the circuit court;

(d) $300 for preparatory work and briefs and all other matters incident to an appeal to the Court of Appeals.

(2) Enforcement of payment of the fee shall be a matter entirely between the counsel or agent and the recipient. The fee shall not be deducted from a public assistance payment otherwise due and payable to the recipient.

Section 20. Burden of Proof. The party bearing the burden of proof shall be determined in accordance with KRS 13B.090(7).

Section 21. Incorporation by Reference. (1) Form PAFS-78, May 1996 edition, Department of Medicaid Services, is incorporated by reference.

(2) This material may be inspected, copied, or obtained at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (21 Ky.R. 2195; eff. 7-5-96; Am. 24 Ky.R. 784; 1104; eff. 11-14-97; 25 Ky.R. 655; 1055; eff. 10-21-98.)